

# PURVIS CHIROPRACTIC CLINIC, PLC

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## APPLICATION FOR NEW PATIENT STATUS

Date: \_\_\_\_\_ Referred by: \_\_\_\_\_ Case No. \_\_\_\_\_  
(for office use only)

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex:  Male  Female

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_ Insurance Company: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Marital Status:  Single  Married  Divorced  Widowed  Living With

Your SSN: \_\_\_\_\_ Spouse's Name: \_\_\_\_\_ Spouse's Occupation: \_\_\_\_\_

Number of Children: \_\_\_\_\_ Children's Name/Ages: \_\_\_\_\_

Past Chiropractic Care?  Yes  No When: \_\_\_\_\_ Chiropractor's Name: \_\_\_\_\_

Results: \_\_\_\_\_ Primary complaint: \_\_\_\_\_

Are your present injuries due to an on-the-job injury?  Yes  No

Have you made a report of your accident to your employer?  Yes  No

Do you plan on turning it in to Workman's Compensation?  Yes  No

Are you now or have you ever been disabled (service or work)?  Yes  No

If yes, when? \_\_\_\_\_ How? \_\_\_\_\_

## ABOUT YOUR HEALTH

Please check any of the following symptoms and signs which you now have or have had within the last 6 MONTHS. An understanding of your health status will help facilitate care.

### GENERAL SYMPTOMS

- Headache
- Fever
- Chills
- Night Sweats
- Fainting
- Dizziness
- Convulsions
- Loss of Sleep
- Fatigue
- Nervousness
- Weight Loss
- Numbness/Pain in Limbs
- Allergy
- Wheezing
- Neuralgia

### SKIN

- Skin Eruptions
- Itching
- Dryness
- Eczema
- Hives/Allergy
- Sensitive Skin
- Boils
- Bruising

### MUSCLES & JOINTS

- Weakness
- Twitching
- Stiff Neck
- Backache
- Swollen Joints
- Tremors
- Foot Trouble
- Painful Tailbone
- Pain between Shoulders
- Hernia
- Spinal Curvation
- Growing Pains
- Faulty Posture

### FOR WOMEN ONLY

- Painful Periods
- Excessive Flow
- Irregular Cycles
- Cramps & Backache
- Hot Flashes
- Vaginal Discharge
- Miscarriage
- Pregnant at this time?

### GASTRO-INTESTINAL

- Poor Appetite
- Poor Digestion
- Excessive Hunger
- Belching or Gas
- Nausea
- Vomiting
- Vomiting Blood
- Pain over Stomach
- Constipation
- Diarrhea
- Colon Trouble
- Hemorrhoids (piles)
- Liver Trouble
- Jaundice
- Gall Bladder Trouble

### GENITO-URINARY

- Frequent Urination
- Kidney Infection
- Bed Wetting
- Inability to Control Urine
- Prostate Trouble

### CARDIO-VASCULAR

- Rapid Heart Rate
- Slow Heart Rate
- High Blood Pressure
- Low Blood Pressure
- Pain over Heart
- Previous Heart Trouble
- Swelling of Ankles
- Poor Circulation
- Varicose Veins
- Heart Attack
- Strokes

### RESPIRATORY

- Difficulty Breathing
- Chronic Cough
- Spitting Phelgm
- Spitting Blood
- Chest Pain

### EYE, EAR, NOSE, THROAT

- Poor Vision
- Crossed Eyes
- Pain in Eyes
- Deafness
- Earache
- Ear Noises
- Ear Discharge
- Nasal Obstruction
- Nose Bleed
- Sore Throat
- Hoarseness
- Hay Fever
- Asthma
- Frequent Colds
- Enlarged Thyroid
- Tonsillitis
- Sinus Trouble

**HAVE YOU EVER HAD ANY OF THE FOLLOWING ILLNESSES/CONDITIONS?**

- |                                  |                                   |                                       |                                       |   |
|----------------------------------|-----------------------------------|---------------------------------------|---------------------------------------|---|
| <input type="checkbox"/> Polio   | <input type="checkbox"/> Flu      | <input type="checkbox"/> Diabetes     | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Heart Disease      |
| <input type="checkbox"/> Anemia  | <input type="checkbox"/> Chorea   | <input type="checkbox"/> Pleurisy     | <input type="checkbox"/> Chickenpox   | <input type="checkbox"/> Scarlet Fever      |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Lumbago  | <input type="checkbox"/> Malaria      | <input type="checkbox"/> Pneumonia    | <input type="checkbox"/> Typhoid Fever      |
| <input type="checkbox"/> Mumps   | <input type="checkbox"/> Eczema   | <input type="checkbox"/> Small Pox    | <input type="checkbox"/> Rheumatism   | <input type="checkbox"/> Rheumatic Fever    |
| <input type="checkbox"/> Cancer  | <input type="checkbox"/> Sciatica | <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Diphtheria   | <input type="checkbox"/> Whooping Cough     |
| <input type="checkbox"/> Goiter  | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Alcoholism   | <input type="checkbox"/> Arthritis    | <input type="checkbox"/> Venereal Infection |
|                                  |                                   |                                       |                                       | <input type="checkbox"/> Mental Disorder    |

**HAVE YOU EVER HAD ANY OF THE FOLLOWING OPERATIONS?**

- |                                       |                     |                                       |                     |   |                     |  |                     |
|---------------------------------------|---------------------|---------------------------------------|---------------------|---|---------------------|--|---------------------|
| <input type="checkbox"/> Tonsilectomy | Surgery date: _____ | <input type="checkbox"/> Hernia       | Surgery date: _____ | <input type="checkbox"/> Thyroid        | Surgery date: _____ | <input type="checkbox"/> Female Organs | Surgery date: _____ |
| <input type="checkbox"/> Appendectomy | _____               | <input type="checkbox"/> Gall Bladder | _____               | <input type="checkbox"/> Rectal Surgery | _____               | <input type="checkbox"/> Back Surgery  | _____               |
- Other Operations: \_\_\_\_\_ Surgery date: \_\_\_\_\_

Accidents or Falls (childhood & adult): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Broken bones or dislocations: \_\_\_\_\_

Have you ever had any spinal taps or spinal injections?  Yes  No \_\_\_\_\_

Were you ever knocked unconscious?  Yes  No \_\_\_\_\_

Have you ever had a lapse of memory  Yes  No When: \_\_\_\_\_

Have you ever had x-rays made of your case?  Yes  No If yes, by whom? \_\_\_\_\_

For what ailment(s) were these x-rays made? \_\_\_\_\_

Do you suffer from any condition(s) other than which you are now consulting us for?  Yes  No

If yes, please list the condition(s) \_\_\_\_\_

Are you presently taking any drugs/medication either prescribed or over-the-counter?  Yes  No

If yes, list drugs/medication: \_\_\_\_\_

**AGREEMENT**

**PLEASE NOTE:** It is understood and agreed that the amount paid to PURVIS CHIROPRACTIC CLINIC, PLC for x-rays is for examination and interpretation only. All x-ray negatives will remain the property of this office, remaining on file, where they may be seen at any time while a patient of this office.

I understand that all services are to be paid in full on the day of service unless other arrangements have been made and agreed on in writing.

\_\_\_\_\_  
*Signature of patient or parent/guardian*

\_\_\_\_\_  
*Date*

I authorize the release of any medical information necessary.

\_\_\_\_\_  
*Signature of patient or parent/guardian*

\_\_\_\_\_  
*Date*

I authorize payment of medical benefits to the PURVIS CHIROPRACTIC CLINIC, PLC

\_\_\_\_\_  
*Signature of patient or parent/guardian*

\_\_\_\_\_  
*Date*